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When doctors from the University of Pennsylvania performed prostate cancer procedures at the Philadelphia VA Medical Center, they made dozens of mistakes over six years, and investigators could find no evidence that anyone was providing oversight, concluded a report issued Monday by the Department of Veterans Affairs Inspector General's Office.

No formal contract existed for many of those years, and the VA ended up overpaying for Penn's services, the report found.

The 110-page report is the last of several probes into the troubled prostate brachytherapy program at the Philadelphia VA, which gave incorrect doses of radiation to 97 of 114 patients treated from February 2002 to June 2008, when it was shut down.

Besides darkening the hospital's reputation, the program has left behind a growing pile of legal claims. In the last several months, seven more veterans have filed claims against the VA, meaning that 38 veterans or their relatives now are seeking $71 million in damages, according to documents obtained through a Freedom of Information Act request by The Inquirer.

For the program's first three years, investigators found that no contract existed between the VA and Penn. After April 2005, the program operated under three- and six-month interim contracts "that violated VA policy." The VA accepts short-term contracts in rare cases, notably emergencies, and does not typically permit them to be renewed for multiple years.

In addition, the report found numerous lapses in oversight.

For example, starting in November 2006, a computer used to perform post treatment quality checks was not connected to the hospital's network, causing 17 men to receive no assessment of their procedures.

"There was almost a culture of incompetence surrounding this particular cancer treatment that let down and put over 100 veterans at risk," said U.S. Rep. John Adler (D., N.J.) one of several local members of Congress to examine the problems at the Philadelphia VA.

"They couldn't get the contracts right, they couldn't get the computer system right, and, finally, they couldn't get the quality of care right," said Adler, who introduced a bill last year to require the VA to report to Congress the performance of small programs such as this to assure better quality oversight.

"VA staff at all levels have cooperated fully to ensure lessons would be learned to strengthen programs system-wide," said Department of Veterans Affairs spokeswoman Katie Roberts in a statement.

Susan E. Phillips, a senior vice president at Penn, could not comment because officials there "had not had an opportunity to review the report."

Prostate brachytherapy involves implanting dozens of tiny radioactive seeds into the acorn-size gland to kill cancerous cells over several months. It is an effective treatment when done correctly.

Records show that the Philadelphia VA's program was deeply flawed from its earliest patients, and that doctors and officials repeatedly missed chances to fix it.

The inspector general's report also examined prostate brachytherapy at 14 other VA facilities that operated programs between 2005 and 2009; only eight are still treating patients. Four voluntarily shut down, and two, in addition to Philadelphia, remain suspended.

Besides Philadelphia, only the Jackson, Miss., program was found to have problems with radiation doses and lack of quality assurance.

While the report detailed multiple opportunities to catch the problems in Philadelphia, the inspector general sided with the Philadelphia VA in concluding that most of these implants were not substandard as defined by nuclear regulators.

Earlier this year, the VA sought to retract 80 of the 97 implants it had reported as medical errors, arguing that the quality of implants was within acceptable limits. The U.S. Nuclear Regulatory Commission, which oversees the medical use of radioactive materials, rejected that argument and imposed a fine of $227,500, which the VA paid in April.

The inspector general's staff wrote that "we do not believe that the . . . 97 total cases reported as 'medical events' constitute poor implants."

The report also concluded that the rates of treatment failure and cancer recurrence for Philadelphia patients "appear within the norm."

Of 114 patients treated, four have since died and 15 - or 13 percent - have had cancer return, according to the report.

The rate of radiation damage to the rectum was also deemed to be normal. Sixteen patients had such damage, but the report concluded only four cases, or 3.5 percent, were serious enough to qualify as "medically significant."

Still, 38 veterans or their wives have filed claims against the Philadelphia VA for alleged injuries. So far, the VA has denied 12 of those claims in letters that state "our investigation of the circumstances of this claim did not reveal any evidence that you suffered symptoms that were not known risks of your cancer treatment."

But once a claim is denied, or six months after it is filed, the veteran has the right to file a federal lawsuit seeking compensation.

To date, two veterans have filed such suits in federal court.

One, Barry Lackro of Philadelphia, got his implant in January 2005. By that April, he had blood in his urine and stools, constipation, rectal pain, and urinary urgency, his records show.

He has since learned that his cancer has returned.

A former Green Beret, Lackro said his $7 million claim was not about money but holding the VA accountable.

One key question in those lawsuits will be whether Penn and its doctors can be sued independently of the VA. That could hinge on the contracts.

"We concluded that from May 1, 1999, through April 25, 2005, PVAMC paid the University of Pennsylvania for radiation therapy services without a contract or other agreement authorizing payment for those services," the report stated.

If there were no agreements, then Penn and radiation oncologist Gary Kao, who performed most of the procedures, could be exposed to separate lawsuits, plaintiffs' lawyers have said.

Kao, who took a leave of absence last summer, returned to his research lab several months ago and is not involved in any clinical care.

Another issue cited in the report involved possible overpayments to Penn.

"VA had little or no control over the hours reported to have been worked," the inspector

general's report stated. "As a result, VA appears to have overpaid for the services provided."

The report did not mention Kao or blame any Penn employees for the program's failures. Members of Congress have criticized the VA for failing to hold anyone accountable for the brachytherapy failures.

But the VA inspector general is not done probing radiation problems at the agency's facilities.

In April, the VA inspector general responded to a request by a bipartisan group of House members to investigate the use of radiation to treat cancer at VA medical centers and for diagnostic tests such as X-rays and CAT scans.

"We are completing preliminary work on a national review of the management and oversight of clinical care in VA involving patient contact with radiation," wrote Inspector General George J. Opfer in a letter obtained by The Inquirer.

"We will focus on areas of greatest apparent potential risk to patients, including external beam radiation and certain diagnostic X-rays," Opfer wrote. "We plan to report on the current status of oversight and compliance at Veterans Health Administration facilities."